		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027086 & 0030528

Facility Name: Bethshan Association I & Bethshan Association II

Address: 12927 South Monitor (Number) Palos Heights (City) 60463 (Zip Code)

County: Cook

Telephone Number: (708) 371-0800 **Fax #** (708) 371-0833

IDPA ID Number: 363038592001 / 363038592002

Date of Initial License for Current Owners: 7/16/82 BI / 2/7/86 BII

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Goudzwaard **Telephone Number:** (708) 371-0800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/04 to 6/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven J. Goudzwaard
(Title) Director of Finance

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # '086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	45	Intermediate/DD	45	16,425	4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	61	TOTALS	61	22,265	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,999			15,999	11
12	SC					12
13	DD 16 OR LESS	5,504			5,504	13
14	TOTALS	21,503			21,503	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.58%

D. How many bed-hold days during this year were paid by the Department?
762 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/16/82 / 2/7/86

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2005 Fiscal Year: 2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethshan Association I & Bethshan Associatio #127086 & 00305 Report Period Beginning: 7/01/04 Ending: 6/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,257	10,570	17,475	171,302		171,302		171,302			1
2	Food Purchase		190,168		190,168		190,168		190,168			2
3	Housekeeping	68,743	20,572	5,307	94,622		94,622		94,622			3
4	Laundry	31,319	2,865		34,184		34,184		34,184			4
5	Heat and Other Utilities			45,489	45,489		45,489		45,489			5
6	Maintenance	57,644	16,587	16,553	90,784		90,784		90,784			6
7	Other (specify):* Scavenger			3,166	3,166		3,166		3,166			7
8	**TOTAL General Services**	300,963	240,762	87,990	629,715		629,715		629,715			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,474,806	52,989	10,479	1,538,274	(12,890)	1,525,384		1,525,384			10
10a	Therapy	75,504	3,786	10,451	89,741		89,741		89,741			10a
11	Activities	148,343	14,134		162,477		162,477		162,477			11
12	Social Services	14,194			14,194		14,194		14,194			12
13	CNA Training					13,165	13,165		13,165			13
14	Program Transportation		23,344		23,344		23,344		23,344			14
15	Other (specify):* Program Director					116,220	116,220		116,220			15
16	**TOTAL Health Care and Programs**	1,712,847	94,253	28,130	1,835,230	116,495	1,951,725		1,951,725			16
	C. General Administration											
17	Administrative	177,431			177,431	(116,220)	61,211		61,211			17
18	Directors Fees											18
19	Professional Services			18,151	18,151		18,151		18,151			19
20	Dues, Fees, Subscriptions & Promotions			13,748	13,748		13,748		13,748			20
21	Clerical & General Office Expenses	113,934	8,550	15,945	138,429		138,429	(8,878)	129,551			21
22	Employee Benefits & Payroll Taxes			607,218	607,218	6,282	613,500	(1,963)	611,537			22
23	Inservice Training & Education			2,660	2,660	(1,378)	1,282		1,282			23
24	Travel and Seminar			7,285	7,285		7,285	(625)	6,660			24
25	Other Admin. Staff Transportation			2,794	2,794	(358)	2,436		2,436			25
26	Insurance-Prop.Liab.Malpractice			46,206	46,206		46,206		46,206			26
27	Other (specify):* Miscellaneous		6,767		6,767	(4,821)	1,946	(966)	980			27
28	**TOTAL General Administration**	291,365	15,317	714,007	1,020,689	(116,495)	904,194	(12,432)	891,762			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,305,175	350,332	830,127	3,485,634		3,485,634	(12,432)	3,473,202			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #0027086 & 00 Report Period Beginning: 7/01/04 Ending: 6/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			172,698	172,698		172,698		172,698			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,719	12,719		12,719	(2,358)	10,361			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			63,960	63,960		63,960		63,960			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			249,377	249,377		249,377	(2,358)	247,019			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			201,260	201,260		201,260		201,260			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			201,260	201,260		201,260		201,260			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,305,175	350,332	1,280,764	3,936,271		3,936,271	(14,790)	3,921,481			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #'086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,358)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,878)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,554)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,790)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (14,790)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bethshan Association I & Bethshan Association II

ID# 0027086 & 0030528

Report Period Beginning: 7/01/04

Ending: 6/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Direct Care Seminars	$ (625)	24	1
2	Fundraising Employee Benefits	(1,963)	22	2
3	Miscellaneous gifts & dinners	(966)	27	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,554)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Bethshan Association I & Bethshan Association II **#** 27086 & 00305 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(8,878)	0	0	0	0	0	0	0	0	0	0	(8,878)	21
22	Employee Benefits & Payroll Taxes	(1,963)	0	0	0	0	0	0	0	0	0	0	(1,963)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(625)	0	0	0	0	0	0	0	0	0	0	(625)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(966)	0	0	0	0	0	0	0	0	0	0	(966)	27
28	**TOTAL General Administration**	(12,432)	0	0	0	0	0	0	0	0	0	0	(12,432)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,432)	0	0	0	0	0	0	0	0	0	0	(12,432)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bethshan Association I & Bethshan Association II** **#27086 & 00305** **Report Period Beginning:** **7/01/04** **Ending:** **6/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,358)	0	0	0	0	0	0	0	0	0	0	(2,358)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,358)	0	0	0	0	0	0	0	0	0	0	(2,358)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(14,790)	0	0	0	0	0	0	0	0	0	0	(14,790)	45

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 00305 Report Period Beginning: 7/01/04 Ending: 6/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bethshan Association	100	Tibstra House	South Holland	Bethshan Foundation	Palos Heights	Charitable Corp

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Bethshan Association I & Bethshan Associat # 0027086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #27086 & 00305 Report Period Beginning: 7/01/04 Ending: 6/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	# beds	127	11	$ 121,189	$ 116,847	61	$ 58,209	1
2	12	Social Services	# beds	127	11	29,073	29,073	61	13,964	2
3	14	Program Transportation	# beds	127	11	38,772		61	18,623	3
4	17	Administrator	# beds	127	11	124,102	124,102	61	59,608	4
5	19	Professional Services	# beds	127	11	33,213		61	15,953	5
6	20	Dues/Fees/Subscriptions	# beds	127	11	19,992		61	9,602	6
7	21	Clerical & General Office	# beds	127	11	254,653	234,740	61	122,314	7
8	22	Workers Comp	budgeted salaries	4,196,200	11	53,507		2,345,138	29,904	8
9	22	Pension	# beds	127	11	10,755		61	5,166	9
10	23	In Service Training	# beds	127	11	794		61	381	10
11	24	Seminars & Workshop	# beds	127	11	3,368		61	1,618	11
12	25	Staff Travel	# beds	127	11	4,221		61	2,027	12
13	26	Liability Insurance	# beds	127	11	37,407		61	17,967	13
14	27	Miscellaneous	# beds	127	11	12,809		61	6,152	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 743,855	$ 504,762		$ 361,488	25

Facility Name & ID Number Bethshan Association I & Bethshan Associati #7086 & 003052E Report Period Beginning: 7/01/04 Ending: 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Bess Tolsema		X	start-up capital		6/26/81	$ 10,000	$ 10,000	on demand	0.1000	$ 1,000	1
2	various noteholders		X	start-up capital		various	190,200	190,200	on demand	0.0600	11,879	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 200,200	$ 200,200			$ 12,879	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 200,200	$ 200,200			$ 12,879	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Bethshan Association I & Bethshan Association II **# 7086 & 0030** **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000		8
	2001		9
	2002		10
	2003		11
	2004		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethshan Association I & Bethshan Association II COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0027086 & 0030528

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Bethshan Association I & Bethshan Association II #27086 & 00305 Report Period Beginning: 7/01/04 Ending: 6/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24602 & 8693 B. General Construction Type: Exterior brick Frame metal Number of Stories 1

C. Does the Operating Entity? [BI] (a) Own the Facility [ ] (b) Rent from a Related Organization. [BII] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	none			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 003052 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	45		1982	1982	$ 1,116,585	$ 20,057	20 - 40	$ 20,057	$	$ 840,125	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodeling & Improvements BI & BII				147,377	6,708	20 - 40	6,708		91,910	9
10	fixed equipment				46,021	2,323	10 to 40	2,323		26,712	10
11	Addition: PT, nursing, office, & maintenance			1993	385,632	9,641	40	9,641		115,690	11
12	Landscaping				18,201	910	20	910		12,355	12
13	Automated door			1999	12,958	1,296	10	1,296		8,069	13
14	Garage				7,000	73	15 - 20	73		6,344	14
15	site improvements BI & BII				125,309	7,116	10 to 20	7,116		79,263	15
16	water & sewer improvements				22,009	734	30	734		16,413	16
17	Woodfold accordian folding partition			2000	2,720	272	10	272		1,367	17
18	Gas heater - Paul Supply			2001	2,593	259	10	259		1,195	18
19	Ceramic Tile - diningroom BI			2001	3,187	319	10	319		1,358	19
20	Besam Automated Entrance BII			2001	1,702	170	10	170		767	20
21	Bathroom remodeling BII			2001	8,455	846	10	846		3,505	21
22	Flat roofs (4) BI			2002	26,100	1,740	15	1,740		6,950	22
23	Bathroom remodeling BII			2002	133,435	8,896	15	8,896		29,653	23
24	Rooms painted (4 pods) BI			2002	6,840	456	15	456		1,561	24
25	Ceramic tile - livingroom BI			2002	4,250	283	15	283		1,005	25
26	Briggs generator BI			2002	2,995	374	8	374		1,170	26
27	Smoking shelter BI			2002	3,972	397	10	397		1,409	27
28	Fire alarm upgrade			2003	9,969	997	10	997		2,873	28
29	Whirlpool room remodeling			2003	6,750	450	15	450		925	29
30	Roof - (BI garage)			2004	2,030	135	15	135		161	30
31	Roof (BI - north)			2005	7,765	289	15	289		289	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 003052 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,103,855	$ 64,741		$ 64,741	$	$ 1,251,069	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 325,849	$ 60,120	$ 60,120	$	5 to 10	$ 265,273	71
72	Current Year Purchases	35,882	3,250	3,250		3 to 8	3,250	72
73	Fully Depreciated Assets	344,514	4,826	4,826		5 to 10	344,514	73
74								74
75	TOTALS	$ 706,245	$ 68,196	$ 68,196	$		$ 613,037	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	client transportation	vans	1996-2005	$ 260,583	$ 33,585	$ 33,585	$	5	$ 207,428	76
77	Executive Director	Mazda Tribute	2003	11,269	2,254	2,254		5	5,279	77
78	Maintenance	Ford F250 Pickup w/plow	2000	15,593	2,842	2,842		5	14,900	78
79	Maintenance	Chevy Silverado 4x4 w/plow	2005	12,248	1,081	1,081		5	1,081	79
80	TOTALS			$ 299,693	$ 39,762	$ 39,762	$		$ 228,688	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,109,793	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 172,699	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 172,699	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,092,794	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Elim Christian Services
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1976	16	7/01/01	$ 63,960	3	3 year renew	3
4	Additions							4
5								5
6								6
7	TOTAL		16		$ 63,960 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning 7/1/04
    Ending 6/30/07

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2006	$ 63,960
13.	6/30/2007	$ 63,960
14.	6/30/2008	$ 63,960

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 27086 & 003052 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER CNA	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER CNA	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		275		275
3	Classroom Wages (a)		3,623		3,623
4	Clinical Wages (b)		7,650		7,650
5	In-House Trainer Wages (c)		1,617		1,617
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 13,165	$	$ 13,165
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,165			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	11
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	11

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 7086 & 0030528 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (750,744)	$ 319,276	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	660,775	1,038,362	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,950	31,002	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (73,019)	$ 1,388,640	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		459,750	13
14	Buildings, at Historical Cost	2,103,856	4,953,192	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,005,938	1,729,940	16
17	Accumulated Depreciation (book methods)	(2,092,795)	(3,268,809)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,016,999	$ 3,874,073	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 943,980	$ 5,262,713	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,210	$ 205,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,971	275,757	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,337	9,620	31
32	Accrued Real Estate Taxes(Sch.IX-B)		1,898	32
33	Accrued Interest Payable	3,856	7,491	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Health Claims Payable	79,809	130,720	36
37	403(B) Contributions Payable	1,540	2,566	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 356,723	$ 633,496	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,200	200,200	39
40	Mortgage Payable		545,860	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 200,200	$ 746,060	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 556,923	$ 1,379,556	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 387,057	$ 3,883,157	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 943,980	$ 5,262,713	48

***(See instructions.)**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 027086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 623,243	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 623,243	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(256,199)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (256,199)	17
	B. Transfers (Itemize):		
18	**Assets transferred from the Building Fund**	20,013	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 20,013	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 387,057	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II #'086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,384,760	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,384,760	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	7,860	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,736	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,596	23
	D. Non-Operating Revenue		
24	Contributions	245,677	24
25	Interest and Other Investment Income***	2,358	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 248,035	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DT Transportation	22,344	28
28a	Gain (Loss) on Assets / Miscellaneous Income	6,337	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,681	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,680,072	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	629,715	31
32	Health Care	1,835,230	32
33	General Administration	1,020,689	33
	B. Capital Expense		
34	Ownership	249,377	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	201,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,936,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	(256,199)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (256,199)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,899	2,122	$ 65,446	$ 30.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,889	6,510	146,546	22.51	3
4	Licensed Practical Nurses	5,159	5,599	113,084	20.20	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist	3,554	4,023	75,504	18.77	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,019	2,204	33,950	15.40	9
10	Activity Assistants	6,627	7,558	114,393	15.14	10
11	Social Service Workers	375	405	14,194	35.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,542	1,852	29,306	15.82	14
15	Cook Helpers/Assistants	9,589	10,369	113,951	10.99	15
16	Dishwashers					16
17	Maintenance Workers	2,998	3,226	57,644	17.87	17
18	Housekeepers	4,789	5,450	68,743	12.61	18
19	Laundry	3,314	3,767	31,319	8.31	19
20	Administrator	866	1,000	61,211	61.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	872	1,000	38,797	38.80	23
24	Clerical	3,814	4,204	75,137	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,596	8,901	171,726	19.29	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	75,868	84,563	978,004	11.57	30
31	Medical Records					31
32	Other Health Ca Program Director	3,213	3,640	116,220	31.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	139,983	156,393	$ 2,305,175 *	$ 14.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	296	$ 17,475	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant	16	285	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	10-3	39
40	Physical Therapy Consultant	47	2,362	10a-3	40
41	Occupational Therapy Consultant	54	2,679	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	60	2,410	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant		3,000	10-3	45
46	Other(specify) Podiatrist	24	2,880	10-3	46
47	Psychiatrist	37	6,714	10-3	47
48					48
49	TOTAL (lines 35 - 48)	534	$ 45,605		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bethshan Association I & Bethshan Association II #'086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joseph Lanenga	Executive Director	0	$ 61,211
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,211

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Dreyer, Ooms, & VanDrunen	Audit & accounting	$ 9,047
ADP	Payroll preparation	6,690
Informability	computer consulting	930
Hoogendoorn & Talbot	legal services	46
Hiskes Dillner O'Donnell	legal services	168
Utility Service Consultant	consultant	270
Patrick Murphy & Assoc	appraisal	1,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,151

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,792
Unemployment Compensation Insurance	6,687
FICA Taxes	165,609
Employee Health Insurance	355,039
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	48,128
Employee Physicals	358
Misc (flowers, gifts, party)	4,821
tuition	1,103
TOTAL (agree to Schedule V, line 22, col.8)	$ 611,537

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Personal use of auto		$ 3,302
TOTAL		$ 3,302

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,118
Health Care Worker Background Check	
(Indicate # of checks performed 43)	435
Employee Professional Fees/Dues	858
Sams Membership	130
Inspection/Bank/Filing Fees	121
DDNA	29
AAMR, IARF, CARF	9,057
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,714
Seminar Expense	4,946
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,660

**See instructions.

Facility Name & ID Number Bethshan Association I & Bethshan Association II # 0027086 & 0030528 Report Period Beginning: 7/01/04 Ending: 6/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethshan Association I & Bethshan Association II #127086 & 0030528 **Report Period Beginning:** 7/01/04 **Ending:** 6/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **n/a** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **201,260**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **1,845** Has any meal income been offset against related costs? **n/a** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **no**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **22,344**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Dreyer, Ooms, & VanDrunen Ltd** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.